STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	03/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION - BROADMEADOW	500 SOUTH BROAD STREET MIDDLETOWN, DE 19709

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from February 21, 2012 through March 6, 2011. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 108. The Stage 2 sample totaled 34 residents.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	F 157 1. R224 has been discharged home from facility. 2. Residents who have incidents have the potential to be affected by this deficient practice.	5/15/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura L. Dittman — TITLE: NHA — (X6) DATE: 3/30/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R224) out of 34 sampled residents the facility failed to consult with the physician and failed to notify the resident's legal representative/emergency contact when R224's foot got caught on the doorway threshold while being pushed in a wheelchair without footrests to a physical therapy session. Findings include: Cross refer F323 R224 was admitted to the facility on 2/20/12 following surgery for a left total knee replacement. On 2/29/12, in an interview with E13 (Physical Therapist), she stated that on 2/25/12 she went to get the resident for therapy at approximately 10 AM. The resident did not have footrests on her wheelchair. E13 stated that when she was pushing R224 through the doorway, the resident's left leg dropped down, her shoe caught on the threshold and her left knee flexed. The resident complained of pain in the left knee. E13 further stated that she did not tell the nursing staff on the unit about the incident. Additionally, E13 stated that she did not see this as an incident, but did use her clinical skills to assess the resident and did not complete an incident report at the time of the incident because she felt that it was not needed.	F 157	3. A. E13 was inserviced to notify the nursing Unit Manager/designee when incident occur so that proper follow through occurs including notification of the resident's legal representative and physician. B. The Staff Developer (SD) will inservice nursing staff on the initiation of an Incident investigation report promptly upon knowledge of an incident. C. The DON/designee will review incident reports to evaluate timeliness, completion, notification of the resident's legal representative and MD notification. 4. The results of the audit will be forwarded to the QA committee for their review. The QA committee will determine the need for futther audits and or action plans.	

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F 157	Continued From page 2 On 2/29/12, in an interview with E12 (CNA), she stated that on 2/25/12 she heard R224 scream, "My Leg" and that R224 was holding her left leg and was crying when the physical therapist was with the resident. A nurse's note (NN) on 2/25/12 timed 11:30 PM stated that the pt verbalized, "I had an accident when I was being transported to therapy this morning and my foot (L) [left] was caught in w/c". The facility failed to notify the physician and the emergency contact who was R224's husband when the incident occurred on 2/25/12. An incident report was completed on the evening shift by nursing and notification was done at 12 AM.	F 157		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the	F 164		

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F 164	Continued From page 3 resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on closed record review and interview, it was determined that the facility failed to ensure the right to personal confidentiality of one (R224) out of 34 Stage 2 sampled residents. Findings include: Review of R224's closed record, revealed that the resident's husband was listed as the "Care Conference Person and Emergency Contact #1". R224's record did not list any other persons who would be privy to any information regarding R224. A nurse's note dated 2/26/12 and timed 2:30 AM, however documented, "daughter aware of current situation. Resident sent out to ER (Emergency Room)". On 3/5/12 in an interview with E2 (Director of Nursing/ DON) he confirmed that R224's daughter was not listed as an emergency contact. At the exit meeting, E2 handed the surveyor an e-mail, dated 3/5/12 at 5:05 PM, in which E15 (RN) wrote, "On February 26, 2012, around 12:15 AM resident (initial of resident) was being sent out to the ER due to complaints of pain and	F 164	F 164 1. R224 was discharged home to facility. 2. All residents have the potential to be affected by this deficient practice. 3. A. The SD/designee will inservice nursing staff on proper notification to POA/next of kin as appropriate. B. DON/designee to review all incident reports to evaluate whether the appropriate POA has been notified. 4. The results of the audit will be forwarded to the QA committee. The QA committee will determine the need for further audit and or action plan.	5/15/12

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F 164	Continued From page 4 redness to left lower leg. Staff nurse told me he tried to contact the husband to notify him of the new order but nobody picked up the phone. Resident told me that her husband usually takes his hearing aid off at night so we were not able to get hold of him. While I was with the resident in her room, she called her daughter using her cellular phone and informed her that she was being sent out to ER, and resident told me we do not have to call her husband bacause (sic) her daughter will let him know." However, review of the medical record lacked evidence of any telephone call being made to R224's emergency contact, her husband.	F 164		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status;	F 272		

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F 272	Continued From page 5 Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that two (R23 and R27) out of 34 sampled residents were assessed accurately. Findings include: 1. R23 was admitted to the facility on 11/10/11 with diagnoses which included pneumonia, congestive heart failure, hypertension, dementia and diabetes mellitus. The initial Minimum Data Set (MDS) assessment, dated 11/17/11 documented in section H0300 that the resident was always continent of bladder. Review of CNA (Certified Nurse's Aide) Data Sheets from 11/10/11 through 11/17/11 revealed that R23 had five (5) documented episodes of bladder incontinence. Additionally, a voiding diary was completed between 11/12/11 and 11/14/11 which documented R23 had eight (8) episodes of	F 272		

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F 272	Continued From page 6 bladder incontinence. An interview with E3 (Registered Nurse Assessment Coordinator-RNAC) on 3/5/11 confirmed that the initial MDS assessment inaccurately stated that R23 was always continent of bladder when it should state he was frequently incontinent. 2A. R27 was admitted to the facility due to sustaining a fractured left hip which required surgery for internal fixation. Additionally, R27 had advanced dementia/Alzheimer's Disease. On 2/24/12, R27 was observed with no teeth. On the same day, via an individual who wanted to remain anonymous, the surveyor was told that the resident no longer uses dentures due to having advanced dementia and that the family chose not to bring the dentures into the facility. The Admission Minimum Data Set Assessment (MDS), dated 1/24/12, section L0200 Dental was checked "Z. none of the above were present" despite having no natural teeth (edentulous). Additionally, "unable to examine" under the dental section was not checked. On 3/2/12, in an interview with E3, (RN Assessment Coordinator/ RNAC), she confirmed that the initial MDS assessment inaccurately coded that there were no dental issues when it should have noted that the resident was edentulous. 2B. Record review revealed that R27 had been a patient of (Name of) Hospice since 2/13/10. Additionally, record review revealed a 1/17/12	F 272	F 272 1. R23 was discharged home from facility. R27 was discharged home from facility. 2. All residents have the potential to be affected by this deficient practice. 3. A. RNAC to review C N A data sheets, all nursing assessments, to include incontinence assessments and voiding diaries, prior to MDS completion/submission. RNAC to conduct 5 weekly random MDS audits to evaluate accuracy. B. RNAC to perform oral examinations on all resident during MDS assessments and code accordingly. RNAC/designee to conduct weekly random MDS audits to evaluate accuracy. C. RNAC to determine presence of hospice services and code MDS appropriately. RNAC to audit weekly random MDS assessments. 4. RNAC to forward audit results to QI committee. QI committee to determine the need for further audit and or action plan.	5/15/12

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F 272	Continued From page 7 hospice note that documented, "Pt (patient) laying in bed at Broadmeadow - just transferred from (Name of hospital) s/p (status post) fall and left hip fracture. Pt alert and oriented to self with expressive aphasia. No verbal or nonverbal indicators of discomfort noted...." The Admission Minimum Data Set Assessment (MDS), dated 1/24/12, section O Special Treatments and Programming was checked, "Z. none of the above" despite having hospice services. On 3/2/12, in an interview with E3, she confirmed that the initial MDS assessment inaccurately coded that there were no hospice services.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who	F 278		

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F 278	Continued From page 8 willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment was accurate for three (R23, R65 and R182) of 34 sampled residents. Findings include: 1a. R23 was admitted to the facility on 11/10/11 with diagnoses which included pneumonia, congestive heart failure, hypertension, dementia and diabetes mellitus. The 11/22/11 14 Day PPS assessment, the 12/6/11 30 day PPS assessment, and the 12/23/11 Readmission/Return MDS assessment, all stated that R23 was always continent of bladder (coded as "0"). Review of the CNA (Certified Nurse's Aide) Flow sheet and voiding diaries, which had been completed during the assessments' review time period, revealed that R23 had been incontinent of bladder multiple times with episodes of continent voiding. A significant change MDS assessment, dated 1/11/12, stated R23 was always incontinent (coded as "3"-no episodes of continent voiding) of	F 278	F278 1A. 1. A. R23 was discharged home from facility. B. MDS correction submitted for R182. C. MDS correction submitted for R65. 2. All residents have the potential to be affected by this deficient practice. 3. A. RNAC to review C N A data sheets and nursing assessments, to include incontinence assessments and voiding diaries, prior to MDS completion/submission. RNAC to conduct weekly random MDS audits to evaluate accuracy. B. RNAC to review with DON/designee all falls and or incidents and code MDS accordingly. RNAC to audit weekly random MDS to evaluate for accuracy.	5/15/12

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F 278	Continued From page 9 bladder. Review of the CNA Flow sheet and voiding diary; which had been completed during the assessment review time period, revealed that R23 had been incontinent of bladder multiple times with episodes of continent voiding. During an interview with E3 (RNAC) on 3/5/12, she acknowledged that all the assessments should have coded R23 as frequently incontinent (code "2"-7 or more episodes of urinary incontinence, but at least one episode of continent voiding) instead of always incontinent (coded "3"). 1b. R23's clinical record revealed a nurse's note, dated 12/2/11 and timed 11:05 PM that stated R23 was found sitting on the floor in the bathroom. The 12/6/11 30 day PPS assessment failed to code R23's fall from 12/2/11. Interview with E3 (RNAC) on 3/5/12 confirmed that R23's fall on 12/2/12 should have been captured on the 12/6/11 30 day PPS assessment. 2. R182 was admitted to the facility on 10/17/11 with diagnoses that included dementia, arthritis, legal blindness and benign prostatic hypertrophy (BPH). The 10/16/11 admission Minimum Data Set (MDS) assessment stated R182 was independent with set up help only (coded as "0,1") for toilet use. Review of the CNA Flow Sheet, which had been completed during the assessments' review time period, revealed that R182 required limited	F 278	4. RNAC to forward audit results to QA committee. QA committee to determine the need for further audit and or action plan.	

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F 278	Continued From page 10 assistance of one staff person (coded as "2,2") for toilet use on at least 5 occasions. During an interview with E3 (RNAC) on 2/29/12, she acknowledged the inaccuracy of the coding on the initial MDS assessment. E3 stated that she does review the CNA Flow Sheets to determine a resident's status for coding on the MDS. 3. R65's initial Minimum Data Set (MDS) assessment, dated 10/19/11, stated in Section L that the resident had loose dentures. Interview with R65 on 3/5/12 revealed that she has always had gum pain associated with her loose fitting dentures. The quarterly MDS assessment, dated 1/19/12, stated in Section L that the resident had no loose dentures and no mouth pain. An interview on 3/2/12 at 3:00 PM with E4 (nurse) and E14 (Social Services) indicated that R65 had a dental appointment on 3/6/12 to address her loose dentures and associated pain. On 3/5/12 at 10:45AM, during an interview with E3 (RNAC), she stated that incorrect coding of the quarterly MDS had occurred and was corrected on 3/2/12.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279		

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F 279	Continued From page 11 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for three (R23, R27 and R182) out of 34 residents sampled, the facility failed to develop care plans for the identified needs of the residents. Findings include 1. R182 was admitted to the facility on 10/17/11 with diagnoses which included dementia, arthritis, legal blindness and benign prostatic hypertrophy (BPH). A physician's order, dated 2/12/12, stated for R182 to receive Ativan 0.25 mg every 6 hours as needed for anxiety. Although the facility developed a care plan on 2/15/12 for "Potential for side effects of psychoactive medication use," they failed to include non-pharmacological interventions to be attempted prior to administration of the Ativan. Cross refer to F315	F 279	F279 1. 1. R182 encouraged to participate in activities, 1:1 visits, and is followed by psych services. Care plan revised accordingly. 2. All residents ordered psychoactive medications have the potential to be affected by this deficient practice. 3. A. SD to inservice nurses on the need to exercise non-pharmacological measures prior to psychoactive medication administration. B. SD to review psychoactive medication orders and conduct weekly random audits. 4. SD to forward results of audit to QA committee. QA committee to determine the need for further audit and or action plan.	5/15/12

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F 279	Continued From page 12 2. R23 was admitted to the facility on 11/10/11 with diagnoses which included coronary artery disease, congestive heart failure, hypertension, diabetes mellitus, chronic obstructive pulmonary disease and dementia. The 11/17/11 initial Minimum Data Set (MDS) assessment triggered the care area of urinary incontinence and was checked off to be addressed in the care plan. Review of CNA Flow Sheets revealed that R23 had episodes of urinary incontinence during the review time period for the assessment. Despite this the facility failed to develop a care plan for R23's urinary incontinence. During an interview with E3 (RNAC) on 3/5/12, she acknowledged that a care plan was not developed for R23's incontinence. 3. R27 was admitted to the facility with diagnoses of a fractured left hip which required surgery and advanced dementia/Alzheimer's Disease. On 2/24/12, R27 was observed with no teeth. On the same day, in a family interview, the surveyor was told that the resident no longer uses dentures due to having advanced dementia and that the family chose not to bring the dentures into the facility. The Admission Minimum Data Set Assessment (MDS), dated 1/24/12, section L0200 Dental was checked "Z. none of the above were present" despite having no natural teeth (edentulous).	F 279	2. 1. R23 discharged home from facility. 2. All residents have the potential to be affected by this deficient practice. 3. A. SD to inservice nurses on initiation of incontinence care plans. B. Unit Manager (UM)/designee to do random weekly audits to evaluate whether incontinence care plans were initiated appropriately. 4. UM will forward findings to QA committee. QA committee will determine need for further action.	

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F 279	Continued From page 13 The facility failed to develop a care plan to address R27's dental status. On 3/2/12, in an interview with E3, (RN Assessment Coordinator/ RNAC), she acknowledged that the initial admission MDS was miscoded in the area of dental and that a care plan should have been developed.	F 279	3. 1. R27 was discharged home from facility. 2. All residents with dental issues have the potential to be affected by this deficient practice. 3. A. SD to inservice nurses on appropriate initiation of dental care plans. B. UM/designee to do random weekly audits to evaluate whether dental care plans were initiated if applicable. 4. UM will forward findings to QA committee. QA committee will determine need for further action.	5/15/12
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being, in accordance with physician's orders for three (R59, R65 and R145) out of 34 sampled residents. The facility failed to monitor fluid restriction requirements and they failed to confer with the dialysis center regarding any updates that may have required a change in treatment for R145. The facility failed to monitor jaw pain for R65 and failed to off load R59's heels in accordance with the written plan of care. Findings include: 1. The facility policy entitled "Hemodialysis Communication Form" stated "Policy: To provide	F 309	F 309 1. 1. R 145 fluid restriction order was clarified. 2. All dialysis residents have the potential to be affected by this deficient practice.	

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F 309	Continued From page 14 a process for the communication of pertinent patient information between dialysis provider and nursing center. Procedure: 1. Utilize the hemodialysis Communication Form to exchange patient information between center staff and hemodialysis provider each time a patient receives out-patient dialysis treatment...3. The bottom portion of the form is completed by the licensed nurse at the dialysis unit and sent back to the center with the patient after treatment. 4. Inform attending physician of any recommendations or new orders received from dialysis center. Document physician's response in patient's clinical record and note and transcribe orders as needed..." R145 was originally admitted to the facility on 1/6/11 with diagnoses which included coronary artery disease, diabetes mellitus, hypertension and ESRD (end stage renal disease. R145 received hemodialysis three times a week at an outside facility. The facility developed a care plan on 2/18/11 for the problem of non compliance with fluid restriction. Interventions included: "allow choices within prescribed diet as allowed; document each shift number of times non compliant on CNA flow sheet; notify MD, dialysis center and family when appropriate..." The 12/29/11 annual Minimum Data Set (MDS) assessment stated that R145 was cognitively intact and received dialysis services. Review of monthly physician order sheets (POS) from 9/2/11 through 2/12 revealed an order for a 1200 ml (milliliter) fluid restriction per 24 hours: nursing to give 270 ml and dietary to give 930 ml.	F 309	3. A. Hydration monitoring to be completed on all dialysis residents by Registered dietitian (RD)/designee. B. RD to follow up on dialysis recommendations and clarify fluid restrictions as needed. 4. RD/designee to forward compliance of fluid restriction status and hydration to QA committee. QA committee to determine need for further audit and or action plan.	

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F 309	Continued From page 15 Review of the clinical record revealed that although the facility was documenting non compliance with fluid restriction, they failed to monitor the fluid amounts that R145 was consuming. Review of meal intake records revealed that fluid amounts consumed by the resident were not monitored separately. The facility failed to have a system in place to monitor the daily fluid amounts. R145's hemodialysis Communication Forms were reviewed from 1/1/12 through 2/27/12. The communication sheets dated 1/11/12, 1/13/12, 1/30/12, 2/3/12, and 2/27/12 all stated under the "Post Dialysis Instructions" section "Fluid Restriction 1 L (one liter or 1000 mls) a Day." There was no evidence in the clinical record that R145's physician had been notified regarding the recommended decrease of daily fluid intake from the dialysis center. R145's orders remained at a 1200 ml fluid restriction during 1/12/ and 2/12. On 2/28/12 at 12:45 PM, R145 was observed during the midday meal. R145's meal ticket stated that she was on a 1200 ml fluid restriction with 930 mls allotted for dietary and divided between 3 meals. R145 was served 8 oz of iced tea and 4 oz of apple juice (total of 360 mls). She had consumed the apple juice, but left the iced tea and instead had a large Styrofoam cup filled with ice and orange soda. On 3/1/12, R145 was again observed during breakfast. She had consumed an 8 oz cup of coffee (240 mls). During an interview with E4 (nurse) on 3/1/12, E4 stated that a folder is sent with the resident each time they go for dialysis. She stated that any	F 309	2. 1. R59 has no pressure areas or skin breakdown on his heels. 2. All residents have the potential to be affected by this deficient practice. 3. SD to inservice nursing staff on offloading. UM to perform random weekly clinical observation rounds to evaluate proper offloading. 4. Results of observation rounds to be forwarded to QA committee. QA to determine need for further rounds and or action plan. 3. 1. R65 pain medication order was clarified with MD. 2. Residents who complain of pain have the potential to be affected by this deficient practice.	

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F 309	Continued From page 16 issues or concerns from the facility are written down and dialysis does the same. When asked how fluid restriction monitoring is completed, she stated that they do not have any 24 hour totals for fluids. E4 stated that nursing is to review the communication sheets upon the residents return from dialysis. When asked if the physician was consulted regarding dialysis recommendations regarding a decreased of fluids to 1000 mls per day, she stated "they must have cut her fluids back more." On 3/3/12 a telephone verbal order was written which stated, "Change fluid restriction to 1000cc (ml)/day as per dialysis recommendation." 2. R59 was admitted to the facility on 2/15/10 with diagnoses that included dementia, anemia; cerebral vascular accident (stroke), and prostate cancer. A care plan, created on 2/17/10 for the "Potential for pressure ulcers related to decreased mobility" included the intervention "Off load heels when in bed." The 12/11/11 annual Minimum Data Set (MDS) assessment stated R59 was at risk of developing pressure ulcers. On 3/1/12, R59 was observed lying in bed at 8:45 AM, 11:15 AM, 12:00 PM, 1:35 PM, and 3:05 PM. R59's heels were observed not being off loaded according to the plan of care. In an interview with E4 (nurse) on 3/1/12 at 3:15 PM regarding the lack of off loading of R59's heels, she stated that the resident was at times	F 309	3. A. Residents are monitored every shift and as needed for pain. Pain scales pre and post pain medication administration is documented to determine effectiveness. B. SD to inservice nurses on new procedure for pain assessment and pain med administration. C.SD/designee to conduct random weekly audit on appropriate pain assessment and medication administration. 4. SD to forward audit results to QA committee. QA committee to determine the need for further audits and or action plans.	

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F 309	Continued From page 17 "non compliant." The clinical record lacked evidence that R59 had refused to have his heels off loaded on that shift. 3. R65 was admitted to the facility on 10/7/11 with diagnoses that included anemia, dementia, diabetes mellitus, hypertension and secondary Parkinsonism. On 12/6/11 a physician's order was written for R65 to receive Ibuprofen 600 mg twice a day as needed for TMJ (Temporal Mandibular Joint) pain and to alternate heat and cold to right TMJ x 10-15 minutes each and repeat 2-3 times as needed. Review of monthly pain flow sheets revealed that staff were tracking back and leg pain, but not the TMJ pain. On 3-5-12 at 10:00 AM, during an interview with E5 (nurse), she stated that R65 had no medication or thermal therapy for TMJ since early December 2011. There was no tracking of TMJ on the pain flow sheets since it was ordered on 12/6/11.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		

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F 315	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of facility policy, it was determined that the facility failed to ensure that a resident who was incontinent of bladder received appropriate treatment and services to restore as much normal bladder function as possible for one (R23) out of 34 sampled residents. The facility failed to accurately assess R23's continence status and failed to evaluate voiding dairies in order to determine voiding patterns and care plan accordingly . Findings include: The facility policy entitled "Incontinence (Treatment)" stated, Purpose: A resident who is incontinent of bladder will receive appropriate treatment and services to prevent urinary tract infection and to restore or improve bladder function to the extent possible...Incontinence Assessment: The first step is to identify residents already experiencing some level of incontinence or at risk for developing urinary incontinence. Every resident will be assessed for incontinence on admission, or re-admission, quarterly and with significant change...Incontinency is Assessed on Admission: 1...Identify those residents who are incontinent, or have experienced a decline in continence. 2. On admission, all residents who code as 1, 2, 3, 0r 4 should have a voiding diary completed...4. After 48 hours, review the Voiding Diary to determine if there is a voiding pattern. When evaluating the Voiding Diary, assess cognitive status and toilet use to determine appropriate plan of care (i.e., toileting plan...)...5. If a toileting plan is developed, monitor the planned toileting times and its results for one	F 315		

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F 315	Continued From page 19 month. Modify the schedule as needed..." Cross refer to F272 example #1, F278 example #1a, and F279 example #2 R23 was admitted to the facility on 11/10/11 with diagnoses which included coronary artery disease, congestive heart failure, hypertension, diabetes mellitus, dementia and chronic obstructive pulmonary disease. The initial Minimum Data Set (MDS) assessment, dated 11/17/11 stated R23 was cognitively intact and required extensive assist of one staff person for transfers and toilet use. This same MDS documented in section H0300 that the resident was always continent of bladder. Review of CNA (Certified Nurse's Aide) Data Sheets from 11/10/11 through 11/17/11 revealed that R23 had five (5) documented episodes of bladder incontinence. Additionally, a voiding diary was completed between 11/12/11 and 11/14/11 which documented R23 had eight (8) episodes of bladder incontinence. Although the initial MDS triggered the care area of urinary incontinence and was checked off to be addressed in care planning, the facility failed to develop a care plan for R23's urinary incontinence. Additionally, the clinical record lacked evidence that the voiding diary was reviewed and evaluated and that an appropriate plan of care was developed. R23 was hospitalized on 12/13/11 and returned to the facility on 12/16/11. The 12/23/11 Readmission/Return assessment stated that R23 was always continent of bladder (coded as "0"). Review of the CNA (Certified Nurse's Aide) Flow sheet and a voiding diary, which had been completed during the assessments' review time	F 315	F315 1. R23 was discharged home from facility. 2. Residents with incontinence have the potential to be affected by this deficient practice. 3. RNAC to perform weekly random audits and determine if voiding diaries are completed as appropriate, and that incontinent residents are receiving appropriate treatment to restore as much normal bladder function as possible. 4. RNAC to forward results of audit to QA committee. QA committee to determine the need for further audit and or action plan.	5/15/12

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F 315	Continued From page 20 period, revealed that R23 had been incontinent of bladder multiple times with episodes of continent voiding. The facility again failed to review and evaluate the voiding diary and failed to develop a care plan for R23's incontinence. R23 was again hospitalized on 12/27/11 and was readmitted to the facility on 1/4/12. A significant change MDS assessment, dated 1/11/12, stated R23 was always incontinent (coded as "3"-no episodes of continent voiding) of bladder. Review of the CNA Flow sheet and voiding diary, which had been completed during the assessment review time period, revealed that R23 had been incontinent of bladder multiple times with episodes of continent voiding. Once again, the facility failed to evaluate the voiding diary and failed to develop a care plan for the incontinence in order to attempt to restore as much normal bladder as was possible for R23. On 3/5/12 at 11:30 AM during an interview, E3 (RNAC) confirmed the inaccuracies of the MDS assessments and the lack of care planning. In an interview on 3/5/12 at 1:00 PM with E2 (Director of Nursing), he stated that the Unit Managers are to review the voiding diaries and develop a toileting schedule for the residents who are incontinent. Despite multiple assessments and voiding diaries being completed for R23, the facility never developed a care plan for incontinence and never evaluated the voiding diaries in an attempt to improve R23's urinary continence status.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 21 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that each resident receives adequate supervision and assistance devices to prevent accidents for 1 (R224) out of 34 Stage 2 sampled residents. The facility failed to ensure R224 utilized bilateral foot rests when transported in a wheelchair. Findings include: On 2/20/12, R224 an alert and oriented resident, was admitted to the facility for rehabilitation after having a left total knee replacement (L TKR) on 2/17/12. An initial Minimum Data Set Assessment (MDS), dated 2/26/12, noted that the assessment was in progress but was not completed (due to being admitted to hospital on 2/26/12). The Fall Risk assessment, dated 2/20/12, had a score of 5, greater than 10 was considered high risk. Review of the ROM assessment, dated 2/21/12, revealed that R224's left knee had a minimal contracture (a condition of fixed high resistance to passive stretch of a muscle) of 8 (range for minimal contracture was 5 - 30) due to the recent surgery.	F 323		

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F 323	Continued From page 22 Review of the Physical Therapy (PT) evaluation and plan of treatment, dated 2/21/12, revealed that R224's, "LLE ROM (left lower extremity range of motion) = (equaled) Impaired (L LE -8 degrees extension ; 60 degrees flexion". The LLE strength was evaluated as, "3/5 (Part moves less than full range against gravity, w (with)/gradual release from test position". Additionally, in the area of skin and edema (swelling) the PT evaluation revealed, "Skin Integrity = Bruises (L LE w/bruising and incision L (left) knee [not viewed]); Edema = Slight Edema (no lasting impression) (significant edema, however pt (patient) does not allow pressure to measure edema)". Review of the PT assessment summary included, "Clinical Impressions: pt present w/ increased edema, increased pain, decreased ROM and decreased mobility due to recent L TKR (left total knee replacement)." A Potential for falls r/t (related to) deconditioning s/p (status post) hospitalization care plan, developed 2/21/12, had interventions which included, "Bed will be positioned in lowest setting appropriate for resident. Encourage resident to use recommended assistive devices as ordered. Fall risk assessment on admission, quarterly, sign change and prn. Non-skid footwear will be provided to all residents. PT/OT services as ordered - refer to therapy care plan for transfer status..." A Potential for impaired mobility due to diagnosis of L TKR care plan, developed 2/21/12, had interventions which included, "Resident requires supervision with transfers. Resident requires a one person assist with transfers. Resident	F 323		

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F 323	Continued From page 23 requires RW (roller walker) for ambulation with NSG (nursing) assist. Resident requires supervision with rolling side to side..." Review of nurses' notes (NN) revealed on 2/20/12 at 9:50 PM, "L thigh to the foot incision c (with) 26 staples OTA (open to air) +2 edema to L foot (LE)... On 2/25/12 1:54 PM the NN documented, "...redness to L shin incision CDI (clean, dry, intact) +2 edema LLE". Review of the PT note, dated 2/25/12 revealed, "Donned TED stocking for pt (patient). Pt. with increased pain in L knee when her foot got caught on the doorway threshold yet this was relieved with ice application. Pt able to ambulate with RW x > 300 ft. with supervision and good WBing (weight bearing) through R LE. Seated PROM R knee flexion". In an interview on 2/29/12 with E12 (CNA), she stated that on 2/25/12 she did not see R224 coming out of her room but heard her scream, "My Leg" and then observed her holding her left leg and crying. E12 stated that E13 (PT/Physical Therapist) was with the resident and was pushing R224 in her wheel chair. E12 stated that she didn't think that there were any foot rests on the wheel chair. E12 stated that E13 then took the resident to physical therapy. E12 stated that she did not report her observation to anyone because, "I thought that therapy would report it". In an interview on 2/29/12 with E13, she stated that she went to get R224 for therapy around 10 AM on 2/25/12. Also, E13 stated that 2/25/12 was her first day providing PT services to the resident. E13 stated that she did not know how R224	F 323		

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F 323	Continued From page 24 usually got to and from therapy and that she thinks she asked the resident and that the resident stated that she wanted to get wheeled to the gym and walk back. E13 stated that the resident had swelling in the left leg. E13 stated that she got a new pair of TED stockings since the other ones were dirty and then put them on R224's legs along with rubber soled shoes. Then R224 got into her wheel chair and was holding her legs up. There were no foot rests on the wheel chair. E13 stated that she encouraged residents with total knee replacement surgery to get the knee flexion and not use the leg rests. E13 stated that she assessed that R224 had enough strength to keep her legs up when being wheeled without foot rests. Further, E13 stated that when she was pushing her through the doorway, R224's left leg dropped down, the shoe caught on the threshold and the resident's left knee flexed. The resident complained of pain in the left knee. E13 stated that she let R224 sit for a few minutes. Then, E13 stated that she put leg rests onto the wheel chair and wheeled the resident down to the gym and put ice on her left knee for about 15 minutes. E13 stated that she did not tell nursing, "I did not see this as an incident, and used my clinical skills to assess. I did not fill out an incident report because it was not needed". Review of a NN dated 2/25/12 at 11:30 PM revealed, "... Medicated with Percocet severe c/o (complaint of) L leg pain. ...Pt verbalized that 'I had an accident when I was being transported to therapy this morning and my foot (L) was caught in w/c'... call bell within reach, will continue to monitor". An incident report was completed by	F 323		

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	085050	A. BUILDING _____ B. WING _____	03/06/2012

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F 323	Continued From page 25 nursing at that time which stated "Resident verbalized that while PT was transporting het to therapy her left leg got caught on her wheelchair. No apparent injury noted." Review of a NN dated 2/26/12 at 2:30 AM, " ...Resident noted crying. Ineffective relief from 2235 (10:35 PM) administration of Percocet. Left shin/calf noted with redness but not warm to touch. +2 edema and dark bruising noted to L foot. NP (on -call) notified at midnight. Daughter aware of current situation. Resident sent out to ER for Eval at 0100 (1:00 AM) via stretcher/ambulance." The "SBAR Physician/NP/PA communication and progress note" dated 2/26/12 and timed 12:10 AM , documented "severe pain in Left Leg unrelieved by medication at 2230, problem gotten worse; incident/injury on day shift involving wheel chair, new onset/ edema, dark bruising, redness. Primary diagnosis (L) TKR; pain level10/10 L leg from foot to knee, not relieved by meds. Assessment: injury or DVT or infection; ER eval..." According to the hospital H&P, dated 2/26/12, R224 was admitted with a diagnosis of left leg cellulitis. The facility failed to ensure that R224 received adequate supervision and the use of foot rests as assistance devices to prevent the 2/25/12 accident. The PT was seeing R224 for the first time on 2/25/12 who had edema of the left leg post L TKR. When foot rests were not used and R224 was unable to hold her left leg over the threshold of her door, her L leg dropped down	F 323	F 323 5/15/12 1. R224 discharged home from facility. 2. All residents have the potential to be affected. 3. A. SD/designee to inservice therapy staff on appropriate use of wheelchair leg rests during transport of residents. B. Random weekly observation audits to be conducted by therapy director/designee. 4. Results of observations/audit to be forwarded to QA committee. QA committee to determine need for further audit and or action plan.	

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F 323	Continued From page 26 causing this preventable accident which was not initially reported to nursing. On 3/5/12, E2 (DON) confirmed the findings.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to ensure that two (R182 and R221) out of 34 sampled residents were free from unnecessary	F 329	F329 1. 1. R182 encouraged to participate in activities, 1:1 visits, and is followed by psych services.	5/15/12

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F 329	Continued From page 27 medications. Findings include: Cross refer to F279 example #1 1. R182 was admitted to the facility on 10/7/11 with diagnoses which included dementia, legal blindness, arthritis, and benign prostatic hypertrophy. On 2/12/12 a physician's order was written for R182 to receive Ativan (benzodiazepine-used for relief of anxiety) 0.25 mg every 6 hours as needed. Psychotropic reduction meeting notes, dated 2/13/12 stated "...clinical/behavioral status: "legally blind, can not keep still anxious/recent death of partner.." A care plan was developed for "potential for side effects of psychoactive medication" use on 2/15/12. The care plan failed to include non-pharmacological interventions to be implemented prior to use of the Ativan. The medication administration record (MAR) documented that Ativan was administered on 2/15/12 at 10:42 AM, 2/16/12 at 11:14 AM and 10:05 PM, 2/17/12 at 9:12 AM, 2/20/12 at 8:52 AM, 2/21/12 at 8:02 AM, 2/22/12 at 8:39 AM, 2/23/12 at 8:41 AM, and 2/29/12 at 9:02 AM (a total of 9 doses). Progress notes revealed documentation that all the above doses were given for anxiety and documented whether it was effective. However, review of nurse's notes lacked evidence of any non pharmacological interventions being attempted prior to use of the Ativan. While the facility ensured that a psychiatric consultation was implemented the facility failed to attempt to	F 329	2. Residents ordered psychoactive medications have the potential to be affected by this deficient practice. 3. A. Nurses to be inserviced on the need to exercise non-pharmacological measures prior to psychoactive medication administration. B. SD to review psychoactive medication orders and conduct weekly random audits. 4. SD to forward results of audit to QA committee. QA committee to determine the need for further audit and or action plan.	

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F 329	Continued From page 28 identify the causes of R65's anxiety and offer non pharmacological interventions prior to using the Ativan. Findings were acknowledged by E1 (Administrator) and E2 (Director of Nursing) during an interview on 3/5/12. 2. On 2/10/12, R221 was admitted to the facility with diagnoses including left total hip replacement, anemia, congestive heart failure, chronic kidney disease and hypothyroidism. Review of the admission orders, dated 2/10/12, revealed that R221's physician ordered Epogen/Procrit 20,000 units/1 ml subcutaneously weekly on Tuesdays. Review of the "Medication Reconciliation Order Sheet for Extended Care Facilities, dated 2/10/12, noted that Epogen/Procrit had been started on 2/7/12 while R221 was still hospitalized. Review of R221's blood work revealed that a complete blood count was done on 2/14/12. R221's hemoglobin was 8.5 G/DL which was low. The 2012 Nursing Drug Handbook used by the facility, noted for Epogen therapy to, "Monitor hemoglobin level twice weekly until stabilized in target range (10-12 g/dl for most patients) and maintenance dose is established, then continue to monitor at regular intervals. Resume twice weekly testing following any dosage adjustments." The facility failed to adequately monitor	F 329	2. 1. R221 discharged home from facility. 2. Residents on Epogen have the potential to be affected by this deficient practice. 3. A. SD to inservice nurses on recommendations from annual Nursing Drug Handbook on appropriate labs for residents on Epogen therapy. B.SD to identify all residents on Epogen and audit lab orders. 4. SD to forward results of audit to QA committee. QA committee to determine need for further audit and or action plan.	

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F 329	Continued From page 29 hemoglobin levels with the use of Epogen for R221. On 3/5/12, in an interview with E17 (RN Unit Manager), she confirmed the findings.	F 329	F371	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to distribute food under sanitary conditions. Findings include: 1. A lunch observation on 2/21/12 in the AJ Cox living room revealed E6 (activity aide) and E7 (activity aide) serving the residents. E6 was observed plating food with gloved hands, then serving residents, cutting their food and touching them. E6 then returned to plating food for other residents without removing the gloves, sanitizing her hands and donning clean gloves. On one occasion, E6 was observed placing her gloved, contaminated hand on the outter rim of a plate to keep the food from spilling off the plate. The contaminated, gloved hand came into direct contact with the food. Findings were reviewed and acknowledged by E1	F 371	1. Food is being handled in safe and sanitary conditions when serving residents. 2. All residents have the potential to be affected by this deficient practice. 3. A. SD to inservice C N As, activities staff, and speech therapist on proper food handling techniques. B.UM/designee will perform random weekly dining observations to evaluate whether sanitary food handling is occurring. 4. UM to forward results of audit to QI committee. QI committee to determine need for further audit and or action plan.	5/15/12

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F 371	Continued From page 30 (Administrator) and E2 (DON) during an interview on 3/5/12. 2. On 2/21/12 12:10 PM, an observation was made of E19 (Speech/Language Pathologist/SLP) touching R101's roll with her bare hands while cutting the roll, then spreading the roll with butter and handing the roll to the resident. The facility failed to serve food under sanitary conditions. In an interview on 2/21/12, E19 acknowledged that she did use her bare hands to handle R 101's roll.	F 371	F428	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based upon record review and interview, it was determined that the monthly Medication Regimen Review (MRR) failed to identify the lack of adequate monitoring for one (R221) out of 34 Stage 2 sampled residents. Findings include: Cross Refer F329 example 2	F 428	1. R221 discharged home from facility. 2. All residents on Epogen have the potential to be affected by this deficient practice. 3. A. SD to inservice nurses on recommendations from annual Nursing Drug Handbook on appropriate labs for residents on Epogen therapy. B. SD to identify all residents on Epogen and audit lab orders. 4. SD to forward results of audit to QI committee. QI committee to determine need for further audit and or action plan.	5/15/12

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F 428	Continued From page 31 R221 was started on Epogen therapy on 2/7/12 according to the hospital/admission orders. Review of R221's record revealed that there was only one lab drawn that included a hemoglobin level on 2/14/12, when R221 had a complete blood count with differential which revealed a low hemoglobin level. A MRR was done for R221 on 2/24/12. However, the MRR failed to recommend labs for Epogen therapy. The 2012 Nursing Drug Handbook used by the facility, noted for Epogen therapy to, "Monitor hemoglobin level twice weekly until stabilized in target range (10-12 g/dl for most patients) and maintenance dose is established, then continue to monitor at regular intervals. Resume twice weekly testing following any dosage adjustments." The facility failed to identify a lack of adequate monitoring of hemoglobin levels for R221 during the MRR, dated 2/24/12. On 3/5/12, in an interview with E17(RN UM), she confirmed the findings.	F 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		

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F 441	Continued From page 32 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to maintain infection control practices designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Findings include:	F 441	F441 1. 1. Glucometers are cleaned per policy after each use. 2. Residents who have blood sugar testing have the potential to be affected by this deficient practice. 3. A. SD to inservice nurses on policy and procedure for cleaning glucometers. B. SD to observe glucometer cleaning during random med pass audits. 4. SD to forward observations/audits to QA committee. QA committee to determine need for further audit and or action plan. 2. 1. Currently, clean laundry is not being placed inappropriately.	5/15/12

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F 441	Continued From page 33 1. During medication pass observation on 2/28/12 at 9:32 AM, E5 (nurse) was observed performing an accu check (testing of blood sugar with a glucometer). Upon completion of the accu check, E5 replaced the glucometer into the medication cart without first cleaning it off. E5 was interviewed immediately afterwards and stated that she always cleans off the glucometer, but that she knew he was the last one she had to do at the time. E5 proceeded to show the surveyor the sanitizing wipes that are used and then cleaned off the glucometer. The facility's policy entitled, "Glucometer Care" stated "Purpose: To prevent the transmission of an infectious agent through a contaminated resident care device. Procedure: 1. Glucometers are to be cleaned with PDI Super Sanicloth wipes (product #Q55172) after every use...3. Once cleaned with the PDI wipe, the glucometer is to be returned to its case or storage container until next needed..." 2. On 2/22/12 at 10:35 AM, E8 and E9, (laundry staff), were observed by two surveyors during a resident interview, delivering clean clothes for the residents residing in the room. E9 was observed laying R76's clean clothes on her roommate's bed while E8 placed the roommate's clothing in her closet. E9 then picked up all of R76's clothes that had been lying on the roommate's bed and placed them in her closet. During an interview on 3/5/12 at 9:15 AM, E8 recalled that E9 placed R76's clean laundry on the roommate's bed. E8 acknowledged that clean clothes should not have been placed on another resident's bed and posed a potential to	F 441	2. All residents have the potential to be affected by this deficient practice. 3. A. Environmental Services Director (ESD) to inservice laundry staff on proper placement of clean laundry. B. B. ESD to do random weekly observations. 4. ESD to forward results of observations to QA committee. QA committee to determine need for further observations and or action plan.	

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F 441	Continued From page 34 spread germs. Findings were discussed on 3/7/12, during the informational meeting with E1 (Administrator) and E2 (Director of Nursing). The facility failed to handle and transport clean laundry to prevent the potential spread of infection from one resident to another. 3. Review of the facility policy, entitled Eye Drop Administration, dated 8/1/08 stated that staff were to wash their hands after administering eye drops to a resident. Review of the facility policy, entitled Hand Hygiene, dated 3/1/07 stated, "... In compliance with CDC (Centers for Disease Control) guidelines, alcohol gel may be used in place of hand washing except: ...Before and after administration of eye drops..." During a medication pass observation on 2/29/12 at 8:50 AM, E10 (nurse) was observed administering eye drops to R15. Afterwards, E10 removed her gloves, discarded them in the trash can near the resident's door, returned to the medication cart and used hand sanitizer to clean her hands. Immediately following this observation, E10 was interviewed and denied knowing about the need to wash her hands with soap and water instead of using alcohol gel. During an interview on 2/29/12 at 9 AM, E11 (unit manager) stated that the nurse needed to wash her hands with soap and water after eye drops administration and glove removal. The facility failed to maintain their infection control program when staff failed to wash their hands after each	F 441	3. 1. There were no adverse effects to R15. 2. All residents who receive eye drops have the potential to be affected by this deficient practice. 3. A. E10 inserviced by SD on proper hand washing technique during administration of eye drops. B. SD/designee to observe that proper technique is occurring during random med pass observations. 4. Results of audit to be forwarded to QA committee. QA committee to determine need for further audit and or action plan. 4. 1. Proper hand washing technique being followed by E20.	

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F 441	Continued From page 35 direct resident contact for which hand washing was indicated by accepted professional practice and per the facility's policies. 4. The facility's Hand Hygiene policy and procedure, effective 3/1/07, was reviewed. The procedure included, "Using antimicrobial soap and water or non antimicrobial soap and water; ...Turn off faucets with clean paper towel". On 2/24/12, an observation was made of E20 (LPN) washing her hands at the sink in the kitchenette on the unit. E20 incorrectly shut the faucet off with her bare hands. Advised of this observation by the surveyor, E20 confirmed that she did shut the faucet off with her bare hands. E20 then proceeded to wash her hands a second time but failed to use soap. Again, E20 confirmed the finding and stated that she did not use soap because she had, " just used soap before" referring to the first handwashing observation.	F 441	2. All residents have the potential to be affected. 3. A. SD to inservice E20 on proper handwashing technique. B. SD to conduct random observations and or audits for proper hand washing technique during monthly Infection Control Rounds. 4. Results of observations to be forwarded to QA committee. QA committee to determine need for further audit and or action plan.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Broadmeadow

DATE SURVEY COMPLETED: March 6, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State report incorporates by reference and also cites the findings specified in the Federal report. An unannounced annual survey was conducted at this facility from February 21, 2012 through March 6, 2012. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 108. The survey sample totaled 34 residents.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 3/6/12, F157, F164, F272,	

Provider's Signature [signature] Title NHA Date 3/30/12

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Wilmington, Delaware 19806
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STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Broadmeadow

DATE SURVEY COMPLETED: March 6, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
16 Del. C., Chapter 11, Subchapter VII, §1162 (a)	F278, F279, F309, F315, F323, F329, F371, F428, F441. **Nursing staffing** **(a) Every residential health facility must at all times provide a staffing level adequate to meet the care needs of each resident, including those residents who have special needs due to dementia or a medical condition, illness or injury. Every residential health facility shall post, for each shift, the names and titles of the nursing services direct caregivers assigned to each floor, unit or wing and the nursing supervisor on duty. This information shall be conspicuously displayed in common areas of the facility, in no fewer number than the number of nursing stations. Every residential health facility employee shall wear a nametag prominently displaying his or her full name and title. Personnel hired through temporary agencies shall be required to wear photo identification listing their names and titles.** **This requirement is not met as evidenced by:** Based on observations made on the Strand Unit of the facility, it was determined that the facility failed to ensure that every employee wore a nametag prominently displaying her name and title. Findings include: 1. On 02/29/12, E16, C.N.A., was observed working on the unit throughout the morning with no nametag prominently displayed.	Cross refer to CMS 2567-L survey date completed 3/6/12: F157, F164, F272, F278, F279, F309, F315, F323, F329, F371, F428, F441. 5/15/12 5/15/12 1. Currently all staff are wearing employee identification. 2. All residents have the potential to be affected. 3. UM/designee will do random observation rounds weekly. 4. Results of observations to be forwarded to QA committee. QA committee to determine need for further action plan.